

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11370

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Route 136</u>		d. STREET ADDRESS <u>RD 1</u>	
3. NAME OF DECEASED (Type or print) <u>Gordon Adams</u> First Middle Last		4. DATE OF DEATH <u>November 11 1956</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-34</u>
9. AGE (In years last birthday) <u>22</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Helper Welding</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ky.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Adams</u>		14. MOTHER'S MAIDEN NAME <u>Bertha Stollard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>402-42-6842</u>	
17. INFORMANT <u>EMERY J. Gilliam</u> Address <u>ABERDEEN MD RD 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture SKUL</u> 819X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>819X</u> (c) DUE TO (c) <u>819X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Comminuted Fracture L. Clavicle</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-object type</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-11-56</u> Hour o. m. <u>11-11</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD Route 136</u>		20f. (City or town) <u>Churchville</u> (State) <u>Hartford Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Loyd C. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Bel A. R. Md.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>Gerzid C. Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Hartford County</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 14/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ERMINA Ky</u>		22d. LOCATION (City, town, or county) <u>ERMINA Ky</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>11-11-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bruce A. Lawrence</u>	

NOV 14 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11395 CERTIFICATE OF DEATH

11371

Reg. Dist. No. 187

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Md</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u>		LENGTH OF STAY (in this place) <u>9 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Benson</u>		TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>George Henry Bachman</u>				4. DATE OF DEATH <u>Nov. 7, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widower</u>		8. DATE OF BIRTH <u>Aug. 15-1877</u>	
9. AGE last birthday <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Greenwood Balto Co.</u>	
13. FATHER'S NAME <u>George Bachman</u>				14. MOTHER'S MAIDEN NAME <u>Sini Ann Dixon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>218-10-4347</u>		17. INFORMANT & ADDRESS <u>Margaret Bachman</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						12 HOURS	
422.1 IMMEDIATE CAUSE (A) <u>CARDIO-RESPIRATORY FAILURE</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO SCLEROTIC CARDIO-VASCULAR DIS.</u>						5 YEARS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1951</u> , to <u>7 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 Nov</u> , 19 <u>56</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>H.P. Kidwell M.D.</u>				DATE SIGNED <u>7 Nov 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 9, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Balto-md</u>	
24. REC'D BY REGISTRAR <u>NOV 16 1956</u>		REGISTRAR'S SIGNATURE <u>Russella Lowmole</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.A. Archer</u>		ADDRESS <u>Benson md</u>	

CERTIFICATE OF DEATH

W-10-10-10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF CLERK

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CLERK

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF CLERK

24. SIGNATURE OF JURY

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CLERK

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF CLERK

32. SIGNATURE OF JURY

33. SIGNATURE OF JUDGE

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF CLERK

BUREAU V. S.

NOV 16 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										11372
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 180
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltair</u>			c. LENGTH OF STAY IN 1b <u>3 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltair</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>RD 3</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>George D. Blevins</u>					4. DATE OF DEATH <u>November 3 1956</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-16-99</u>		9. AGE (In years last birthday) <u>57</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Jewelry</u>		11. BIRTHPLACE (State or foreign country) <u>Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John Blevins</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Sigmund</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>1917-21</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Leo Blevins, RD 3 Beltair</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending toxicological tests</u> 420.1 DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>										
ACTUAL SIGNATURE <u>Lorald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>11/3/56</u>					
EXAMINER'S NAME (Type) <u>Gerold C Palmer MD</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richmond Ky</u>		22d. LOCATION (City, town, or county) (State) <u>Richmond, Ky.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T Inter Bel Air Md</u>					24a. REC'D BY REGISTRAR <u>DATE 11-4-56</u>		24b. REGISTRAR'S SIGNATURE <u>Pruella Lowwood</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *John Doe*
 SEX: *Male* AGE: *45*
 DATE OF DEATH: *10/15/56*
 PLACE OF DEATH: *Home*
 CAUSE OF DEATH: *Heart Disease*
 MANNER OF DEATH: *Natural*
 SIGNATURE OF EXAMINER: *[Signature]*
 OFFICE OF THE MEDICAL EXAMINER: *[Signature]*

BUREAU V. 1

NOV 2 1956

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10/15/56
John Doe
Heart Disease

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11381

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11373

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN lb 24	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 127 South Stokes	
3. NAME OF DECEASED (Type or print) First MARVEL Middle THOMAS Last BROOKS		4. DATE OF DEATH Month November Day 27 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 April 1933
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months 23 Days 23 Hours 23 Min.	IF UNDER 24 HRS. Hours 23 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Brooks	
14. MOTHER'S MAIDEN NAME Lara Cudill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No	
16. SOCIAL SECURITY NO. 216-28-5011		17. INFORMANT Mrs. M.T. Brooks Address Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of the head 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during altercation	
20c. TIME OF INJURY Month, Day, Year 1:45 a.m. Nov. 27 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) Aberdeen Harford Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/27/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/56	
22c. NAME OF CEMETERY OR CREMATORY Sharon Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Harford Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Varring		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR Nov 28-56		24b. REGISTRAR'S SIGNATURE William R. Perry	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MA.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
JAMES DOUGLAS		35		Male		White		11/11/1956		BOSTON, MASS.	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		MARRIED		NONE	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer		Signature of Undertaker		Signature of Witness	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 4

NOV 20 1956

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MA.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11374

11401 CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood R.D.		c. LENGTH OF STAY IN 1b 29 yrs.,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood R.D.,	
d. STREET ADDRESS Van Bibber		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alonzo First A. Middle Bullis Last		4. DATE OF DEATH Month Nov. Day 10 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 29, 1909
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		10b. KIND OF BUSINESS OR INDUSTRY Home Construction	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Bullis		14. MOTHER'S MAIDEN NAME Roxie Elledge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-16-8074	
17. INFORMANT Mrs. Verna C. Bullis, Edgewood, Md.,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 8 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002X Pulmonary Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1 , 19 56 to 11-10 , 19 56 , that I last saw the deceased alive on 11-9 , 19 56 , and that death occurred at 5A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Gerald C Palmer Bel Air, Md.		ADDRESS (Street, city or town, state) Bel Air, Md. DATE SIGNED 11-12-56	
PHYSICIAN'S NAME (Type) Gerald C Palmer - M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 12, 1956	
22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son Howard K. McComas		ADDRESS Abingdon, Md.	
24a. REC'D BY REGISTRAR Nov 13, 1956		24b. REGISTRAR'S SIGNATURE Norma G. Moore	

NOV 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG207 11-19-56 et

11382

CERTIFICATE OF DEATH

11375

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>HARFORD.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	c. LENGTH OF STAY IN 1b <u>8 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Rt. # 1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Christina</u> First Middle Last <u>Burkheimer</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>11</u> Year <u>1956.</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 13 - 1882</u> 14 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hohu</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Raymond Podolsky</u> <u>3430 Dudley Ave Baltimore, Md.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Amelia Hiesty</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-cardiovascular Accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260x</u> (b) <u>Arterio-sclerotic C-V Disease.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>sys</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 30, 1956</u> , to <u>Nov 11, 1956</u> , that I last saw the deceased alive on <u>Nov 11, 1956</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Ralph Horby</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Churchville Md Nov 11, 1956</u>	
PHYSICIAN'S NAME (Type) <u>J. Ralph Horby MD</u>		<u>Churchville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 14-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Frederick Rd. Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wippel Bros.</u>		24a. REC'D BY REGISTRAR <u>1800 E. Lombard St. 311</u> DATE <u>NOV 14 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis</u>			

BUREAU V. S.

NOV 14 1956

RECEIVED

11383

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Law Street				d. STREET ADDRESS 106 Law Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Emma Middle M. Last Byrd				4. DATE OF DEATH Month November Day 29 Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 July 1871	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Ross				14. MOTHER'S MAIDEN NAME Rebecca Squares			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Thomas Warfield		Address Box 326 Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 420.0 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 hr yes yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11/15 , 19 56 to 11/29 , 19 56 that I last saw the deceased alive on 11/29 , 19 56 , and that death occurred at 3:28 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE F. J. Hatem				ADDRESS (Street, city or town, state) 17 N. Ch. 1st Rd. Aberdeen, Md.			
DATE SIGNED 11/29/56							
PHYSICIAN'S NAME (Type) Frederick J. Hatem, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/56		22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) Rd. Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barrington				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Dec 2-56	
24b. REGISTRAR'S SIGNATURE Nellie R. Perry							

CERTIFICATE OF DEATH

1956

131

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Dec 10 1956		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Teacher		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Address of Deceased		City		State	
123 Main St		Baltimore		MD	
Box 210		Phone		Hospital	
[Box]		[Phone]		[Hospital]	

BUREAU V. S.

DEC 5 1956

RECEIVED

Date of Report		Reported by		Remarks	
Dec 15 1956		John Doe		[Remarks]	
Signature of Reporter		Signature of Reviewer		Signature of Approver	
[Signature]		[Signature]		[Signature]	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11377

11402 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Forest Hill</u>		<u>4</u> Years		TOWN <u>Forest Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)				Nov. 15 1956			
<u>William Leonard Cullum</u>							
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>January 31, 1874</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired farmer</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Cullum</u>				<u>Martha Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NG</u>				<u>Mrs. Annie Watters, Forest Hill, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
592x IMMEDIATE CAUSE (A) <u>Hypostatic pneumonia terminating</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO						<u>2 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO						<u>??</u>	
(C) <u>Chr. Interstitial Nephritis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>None</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 1953</u> to <u>Nov. 15, 1956</u> , that I last saw the deceased alive on <u>Nov. 15, 1956</u> , and that death occurred at <u>7:20 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Willard R. Hudson</u> M.D. <u>Forest Hill, Md.</u>				ADDRESS (Street, city, town, state) <u>Nov. 16, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>BEL Air Memorial Gardens</u>		LOCATION (City, town, or county) <u>BEL Air, Harford Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster</u>		ADDRESS <u>BEL Air, Md.</u>	
DATE <u>11-16-56</u>							

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

File No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF DISTRICT ATTORNEY

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF CITY CLERK

22. SIGNATURE OF VICE-MAYOR

23. SIGNATURE OF ALDERMAN

24. SIGNATURE OF COMMON COUNCILMAN

25. SIGNATURE OF BOARD OF HEALTH

26. SIGNATURE OF BOARD OF CHARITIES

27. SIGNATURE OF BOARD OF EDUCATION

28. SIGNATURE OF BOARD OF FIRE ALARMS

29. SIGNATURE OF BOARD OF FIRE PREVENTION

30. SIGNATURE OF BOARD OF FIRE SAFETY

31. SIGNATURE OF BOARD OF FIRE INSURANCE

32. SIGNATURE OF BOARD OF FIRE PROTECTION

33. SIGNATURE OF BOARD OF FIRE RESISTANCE

34. SIGNATURE OF BOARD OF FIRE SAFETY

35. SIGNATURE OF BOARD OF FIRE INSURANCE

36. SIGNATURE OF BOARD OF FIRE PROTECTION

37. SIGNATURE OF BOARD OF FIRE RESISTANCE

38. SIGNATURE OF BOARD OF FIRE SAFETY

39. SIGNATURE OF BOARD OF FIRE INSURANCE

40. SIGNATURE OF BOARD OF FIRE PROTECTION

41. SIGNATURE OF BOARD OF FIRE RESISTANCE

42. SIGNATURE OF BOARD OF FIRE SAFETY

43. SIGNATURE OF BOARD OF FIRE INSURANCE

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF DISTRICT ATTORNEY

20. SIGNATURE OF COUNTY CLERK

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35. SIGNATURE OF BOARD OF FIRE INSURANCE

36. SIGNATURE OF BOARD OF FIRE PROTECTION

37. SIGNATURE OF BOARD OF FIRE RESISTANCE

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40. SIGNATURE OF BOARD OF FIRE PROTECTION

41. SIGNATURE OF BOARD OF FIRE RESISTANCE

42. SIGNATURE OF BOARD OF FIRE SAFETY

43. SIGNATURE OF BOARD OF FIRE INSURANCE

RECEIVED

BUREAU V. E.

NOV 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,7 FilmG207 11-26-56 et

CERTIFICATE OF DEATH

11403

113782

Reg. Dist. No. 1782

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upper Cross Roads</u>				c. LENGTH OF STAY IN 1b <u>62 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>Fallston, RD Maryland</u>			
3. NAME OF DECEASED (Type or print) <u>George Washington Famous</u>				4. DATE OF DEATH <u>Nov 9th 1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 24th 1894</u>	9. AGE (In years last birthday) <u>62 yrs.</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Building</u>		11. BIRTHPLACE (State or foreign country) <u>Upper Cross Roads</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Parker Famous</u>				14. MOTHER'S MAIDEN NAME <u>Rosalie Swarner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-01-0917</u>		17. INFORMANT <u>Mr E Idelle Famous</u> Address <u>Fallston Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 CORONARY THROMBOSIS</u> DUE TO (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u> <u>3 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/14</u> , 19 <u>53</u> , to <u>11/9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/17</u> , 19 <u>56</u> , and that death occurred at <u>12:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James Thomson Jr</u> M.D. <u>Garrettsville, Ind.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>S. JAMES THOMSON, JR. MD</u> <u>Garrettsville, Ind.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Men Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Hartford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marion E Kurtz</u> ADDRESS <u>Garrettsville Md</u>				24a. REC'D BY REGISTRAR <u>DATE 11-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>Buella Lowood</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11379

Reg. Dist. No.

185-

11384

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUCE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
c. LENGTH OF STAY IN 1b 1 1/2 DAYS		d. STREET ADDRESS MT. ARARAT FARMS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl First Middle Last GELLRICH		4. DATE OF DEATH Month November Day 5 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/56
9a. AGE (In years lost birthday) yrs. 1 1/2		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 12 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY NEWBORN	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HELMUT GELLRICH		14. MOTHER'S MAIDEN NAME KIARA AMELING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia baby - Rtelcofosis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 11 1/2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 3 , 1956, to Nov 5 , 1956, that I last saw the deceased alive on Nov 4 , 1956, and that death occurred at 123 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE G. H. Richards		M.D. Port Deposit, Md. 11/5/56	
PHYSICIAN'S NAME (Type) G. H. Richards Jr.		ADDRESS (Street, city or town, state) Port de Pasit - Md.	
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/56	
22c. NAME OF CEMETERY OR CREMATORY MT. CECIL		22d. LOCATION (City, town, or county) (State) Harrod Clau. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home of Port Deposit		ADDRESS Port Deposit, Md.	
24a. REC'D BY REGISTRAR Nov. 6 - 56		24b. REGISTRAR'S SIGNATURE G. L. Lewis	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11380
187

11404 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reckordville		c. LENGTH OF STAY IN 1b 7 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reckordville		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reckord Road	
d. STREET ADDRESS Reckord Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine E. Middle Glock Last		4. DATE OF DEATH Month November 15, Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Erker		14. MOTHER'S MAIDEN NAME Unknown Lemke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George Glock		Address Reckord Road. Reckordville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalisata DUE TO (c) 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of bladder INTERVAL BETWEEN ONSET AND DEATH 3 days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 Nov, 1956, to 15 Nov, 1956, that I last saw the deceased alive on 13 Nov, 1956, and that death occurred at 8:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles Richardson, M.D.		ADDRESS (Street, city or town, state) 126 S. Main Bel Air, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Charles Richardson, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19, 1956	
22c. NAME OF CEMETERY OR CREMATORY Jerusalem Lutheran		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24a. REC'D BY REGISTRAR NOV 19 1956	
ADDRESS 7401 Belair Rd.		24b. REGISTRAR'S SIGNATURE Prescilla L. Woods	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11381

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Steven</u> Middle <u>Ray</u> Last <u>Grace</u>			4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 24, 1936</u>		9. AGE (In years last birthday) yrs. <u>20</u> Months <u>2</u> Days <u>2</u> Hours <u>15</u> Min. <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Calvin Grace</u>			14. MOTHER'S MAIDEN NAME <u>Mary Mainer</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Calvin Grace Street, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>1956</u> , that I last saw the deceased alive on <u>November 26, 1956</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Erlinda L. Marbella, M.D.</u>				ADDRESS (Street, city or town, state) <u>Harford Memorial Hospital</u> DATE SIGNED <u>11-26-56</u>	
PHYSICIAN'S NAME (Type) <u>Erlinda L. Marbella</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel cemetery Rd. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarring</u>		ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11-29-56</u> 24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis m.c.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45 years"]		DATE OF BIRTH [Faint text, possibly "1910"]	
PLACE OF BIRTH [Faint text, possibly "New York City"]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF MARRIAGE [Faint text, possibly "1935"]	
PLACE OF DEATH [Faint text, possibly "Home"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
MEDICAL HISTORY [Faint text, possibly "Hypertension"]		PRESENT ILLNESS [Faint text, possibly "Sudden death"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
DATE OF DEATH [Faint text, possibly "Nov 30 1936"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]		NAME OF FUNERAL HOME [Faint text, possibly "St. Mary's"]	

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 BUREAU V. S.

11405 CERTIFICATE OF DEATH

11382

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pylesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pylesville</u>	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Cora</u> First <u>Scott</u> Middle <u>Harrison</u> Last		4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 26, 1885</u>
9. AGE (In years <u>71</u> birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Fawn Groves, Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Andrew Scott</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Enfield</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>T. Elmer Harrison</u>		Address <u>Pylesville, RD, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary thrombosis preceded by 25 yr. Cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov 10</u> , 19 <u>56</u> , to <u>Nov 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>56</u> , and that death occurred at <u>4</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward W. Hyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Fawn Grove, Pa.</u>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Edward W. Hyson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-6-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fawn Grove Meth. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Fawn Grove, York Co., Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Pishman</u>		ADDRESS <u>Stewartstown Pa.</u>	
24a. REC'D BY REGISTRAR DATE <u>11-7-56</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES ALLEN		2. SEX Male	
3. AGE 65		4. RACE White	
5. DATE OF DEATH Nov 8 1956		6. PLACE OF DEATH Home	
7. TIME OF DEATH 10:00 AM		8. CAUSE OF DEATH Heart Disease	
9. DISEASE OR INJURY Coronary Artery Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF PHYSICIAN J. H. Smith		12. SIGNATURE OF REGISTRAR J. H. Smith	
13. SIGNATURE OF DECEASED James Allen		14. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
15. SIGNATURE OF DECEASED James Allen		16. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
17. SIGNATURE OF DECEASED James Allen		18. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
19. SIGNATURE OF DECEASED James Allen		20. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
21. SIGNATURE OF DECEASED James Allen		22. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
23. SIGNATURE OF DECEASED James Allen		24. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
25. SIGNATURE OF DECEASED James Allen		26. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
27. SIGNATURE OF DECEASED James Allen		28. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
29. SIGNATURE OF DECEASED James Allen		30. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
31. SIGNATURE OF DECEASED James Allen		32. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
33. SIGNATURE OF DECEASED James Allen		34. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
35. SIGNATURE OF DECEASED James Allen		36. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
37. SIGNATURE OF DECEASED James Allen		38. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
39. SIGNATURE OF DECEASED James Allen		40. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
41. SIGNATURE OF DECEASED James Allen		42. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
43. SIGNATURE OF DECEASED James Allen		44. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
45. SIGNATURE OF DECEASED James Allen		46. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
47. SIGNATURE OF DECEASED James Allen		48. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
49. SIGNATURE OF DECEASED James Allen		50. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
51. SIGNATURE OF DECEASED James Allen		52. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
53. SIGNATURE OF DECEASED James Allen		54. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
55. SIGNATURE OF DECEASED James Allen		56. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
57. SIGNATURE OF DECEASED James Allen		58. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
59. SIGNATURE OF DECEASED James Allen		60. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
61. SIGNATURE OF DECEASED James Allen		62. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
63. SIGNATURE OF DECEASED James Allen		64. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
65. SIGNATURE OF DECEASED James Allen		66. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
67. SIGNATURE OF DECEASED James Allen		68. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
69. SIGNATURE OF DECEASED James Allen		70. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
71. SIGNATURE OF DECEASED James Allen		72. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
73. SIGNATURE OF DECEASED James Allen		74. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
75. SIGNATURE OF DECEASED James Allen		76. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
77. SIGNATURE OF DECEASED James Allen		78. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
79. SIGNATURE OF DECEASED James Allen		80. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
81. SIGNATURE OF DECEASED James Allen		82. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
83. SIGNATURE OF DECEASED James Allen		84. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
85. SIGNATURE OF DECEASED James Allen		86. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
87. SIGNATURE OF DECEASED James Allen		88. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
89. SIGNATURE OF DECEASED James Allen		90. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
91. SIGNATURE OF DECEASED James Allen		92. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
93. SIGNATURE OF DECEASED James Allen		94. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
95. SIGNATURE OF DECEASED James Allen		96. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
97. SIGNATURE OF DECEASED James Allen		98. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	
99. SIGNATURE OF DECEASED James Allen		100. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith	

RECEIVED
NOV 9 1956
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11383

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dorsey Ave</u>				d. STREET ADDRESS <u>Dorsey Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lee</u> Middle <u>W.</u> Last <u>Haskins</u>				4. DATE OF DEATH Month <u>November</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>e</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13 Sept. 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Various kinds work</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-0462-A</u>		17. INFORMANT <u>Junies Haskins</u> Address <u>Aberdeen, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Hartford County</u>				DATE SIGNED <u>11-26-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rd. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Serrano</u>				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
24b. REGISTRAR'S SIGNATURE <u>Nellie R. Henry</u>				DATE <u>Mar 28-56</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

STATE OF TEXAS
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Illegible]

2. SEX: [Illegible]

3. AGE: [Illegible]

4. DATE OF DEATH: [Illegible]

5. TIME OF DEATH: [Illegible]

6. PLACE OF DEATH: [Illegible]

7. CAUSE OF DEATH: [Illegible]

8. MANNER OF DEATH: [Illegible]

9. SIGNATURE OF MEDICAL EXAMINER: [Illegible]

10. SIGNATURE OF WITNESS: [Illegible]

11. SIGNATURE OF CORONER: [Illegible]

12. SIGNATURE OF JURY: [Illegible]

13. SIGNATURE OF JUDGE: [Illegible]

14. SIGNATURE OF CLERK: [Illegible]

15. SIGNATURE OF [Illegible]

16. SIGNATURE OF [Illegible]

17. SIGNATURE OF [Illegible]

18. SIGNATURE OF [Illegible]

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98. SIGNATURE OF [Illegible]

99. SIGNATURE OF [Illegible]

100. SIGNATURE OF [Illegible]

RECEIVED
JUL 30 1956
BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11384

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Md.</u> b. COUNTY <u>3Y01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 25</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>APG Station Hospital</u>		d. STREET ADDRESS <u>2942 Carver Road</u>	
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>O.</u> Middle <u>Hawkins</u> Last		4. DATE OF DEATH <u>November 17</u> 19 <u>56</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14, 1930</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR <u>26</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov. Social Security</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>James Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Frances Skinner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO. <u>214-26-6433</u>	
17. INFORMANT <u>Mrs Evelyn J Hawkins</u> Address <u>2942 Carver Rd Baltimore - 25, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>819x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>819x</u> DUE TO (c) <u>819x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Auto accident auto-object type</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>11-17-56</u> Hour a. m. <u>11:30</u> p. m. <u>11:30</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Edgewood Harford Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Lerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <u>Harford County 11-17-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E Bulluck</u> ADDRESS <u>Harford County, Md</u>		24a. REC'D BY REGISTRAR <u>Nov 21-56</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Nellie R Perry</u>	

11387

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	c. LENGTH OF STAY IN 1b <i>14 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i> 31	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Edmund St. Est</i>		d. STREET ADDRESS <i>Edmund St. Est</i>	
3. NAME OF DECEASED (Type or print) First <i>FANNIE</i> Middle <i>JACKSON</i> Last <i>JACKSON</i>		4. DATE OF DEATH Month <i>11</i> Day <i>29</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-20-1871</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Steven Harris</i>		14. MOTHER'S MAIDEN NAME <i>Harriett Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT Address <i>Mrs. William H. Harris - Aberdeen, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Dis. = Cardio Renal Syndrome</i> (c) <i>Arteriosclerotic Heart Dis. = Cardio Renal Syndrome</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/15</i> , 19 <i>56</i> , to <i>11/28</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11/28</i> , 19 <i>56</i> , and that death occurred at <i>10:00 A</i> . M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		ADDRESS (Street, city or town, state) <i>569 Revolution St., Havre de Grace, Md.</i>	
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		DATE SIGNED <i>11/30/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-2-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Aberdeen, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Otelia J. Bullock, Havre de Grace, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Nov. 30-56</i>	24b. REGISTRAR'S SIGNATURE <i>Willie R. Perry</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

DEC 3 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11407 CERTIFICATE OF DEATH

11386

Reg. Dist. No. 181

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAH Aberdeen Proving Ground		d. STREET ADDRESS 9 Fern	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George A. Heu Jackson		4. DATE OF DEATH Month November Day 11 Year 19 56	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Nov '56
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 45	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME George Sanford Jackson		14. MOTHER'S MAIDEN NAME Hilda Maria Modli	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Father A J IN #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 45 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11 Nov. 19 56 , to 11 Nov. 19 56 , that I last saw the deceased alive on 11 Nov. '56 , and that death occurred at 10:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Joseph R. Gabriels M.D. USAH (2151-1), APG, MD PHYSICIAN'S NAME (Type) Joseph R. Gabriels, M. D. Nov 11th 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Removal	11/14/1956	Post Cemetery	Army Chemical Center, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John Sarring		24a. REC'D BY REGISTRAR Nov. 14-56	
ADDRESS Aberdeen Md.		24b. REGISTRAR'S SIGNATURE Nellie R. Perry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

NOV 19 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11387

11408 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Whitehall</u>		LENGTH OF STAY (in this place) <u>4 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Whitehall</u>		OR <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>Arthur</u> (Last) <u>Jones</u>				(Month) <u>November</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 22, 1878</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
					Months <u>4</u> Days <u>14</u>	Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Grassy Creek N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas D Jones</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Pugh White Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Ronald B Jones</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>				Probably <u>5 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized arteriosclerosis</u>				Probably <u>10 years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 14</u> , 19 <u>53</u> , to <u>Oct. 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 28</u> , 19 <u>56</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert Barthelet</u> M.D.				DATE SIGNED <u>Forest Hill, Maryland 11-6-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov 8-56</u>		NAME OF CEMETERY OR CREMATORY <u>Wm Waters Mem. Cochetown n. Harford Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>11-9-56</u>		REGISTRAR'S SIGNATURE <u>Pucella Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Martin G. Gentry</u> ADDRESS <u>Jenetteville road,</u>			

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Retired -

Thomas D. Jones

Nov 14. 8 70 1/2

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Grayson, N.C.

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1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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The Mr. C. W. Waters

NOV 13 1956

BUREAU

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11409 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1, Film G209 1-25-57 et

11388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Itasca</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <i>New Jersey</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Passaic</i> 47x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Route # 40.</i>		d. STREET ADDRESS <i>976 Main Ave.</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Brownie — Juno</i>		4. DATE OF DEATH Month Day Year <i>November 3 19 56</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/13/1918</i>
9. AGE (In years last birthday) <i>38</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Luspector</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Steel Industry</i>	
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Marshall Juno.</i>		14. MOTHER'S MAIDEN NAME <i>Mary Partyka.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>War II</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Heben Kucera</i> Address <i>Passaic, N.J.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull</i> 812x DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Compound, comminuted fracture both bones R leg</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident, auto-pedestrian type</i>	
20c. TIME OF INJURY Month, Day, Year <i>11-2 19 56</i> Hour of m. p. m. <i>11-2</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>US Route 40</i>		20f. (City or town) <i>Aberdeen</i> (County) <i>Harford</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>Harford County</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>11/26/1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Woods Rest Cemetery</i>		22d. LOCATION (City, town, or county) <i>River Edge</i> (State) <i>N.J.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Yarrig</i>		24. REC'D BY REGISTRAR <i>Nov 7-56</i>	
ADDRESS <i>Aberdeen Md.</i>		24b. REGISTRAR'S SIGNATURE <i>William R. Perry</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
11-10-56 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible] AGE: [illegible]
3. RACE: [illegible] BIRTH DATE: [illegible]
4. PLACE OF BIRTH: [illegible]
5. OCCUPATION: [illegible]
6. MARITAL STATUS: [illegible]
7. PRESENT ADDRESS: [illegible]
8. DATE OF DEATH: [illegible] TIME: [illegible]
9. PLACE OF DEATH: [illegible]
10. CAUSE OF DEATH: [illegible]
11. MANNER OF DEATH: [illegible]
12. SIGNATURE OF EXAMINER: [illegible]
13. SIGNATURE OF WITNESS: [illegible]
14. SIGNATURE OF CORONER: [illegible]

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NOV 9 1956

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11410 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital		d. STREET ADDRESS 12 Glyndon Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle Claude Last King		4. DATE OF DEATH Month November Day 13 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 6, 1956
9. AGE (In years last birthday) yrs. 75 4 4		IF UNDER 1 YEAR Months 7 Days 4	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Raymond King		14. MOTHER'S MAIDEN NAME Jacqueline Raymonde Laine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address (as in 2 above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Congenital heart disease - cytotoxic DUE TO (c) - Type undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 6, 19 56 , to November 13, 19 56 , that I last saw the deceased alive on November 13, 19 56 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. Augustsson M.D.		ADDRESS (Street, city or town, state) 2151-1 US Army Hosp. Aberdeen Gr. Co.	
PHYSICIAN'S NAME (Type) H AGUSTSSON, MD		DATE SIGNED Nov 13, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 14, 1956	22c. NAME OF CEMETERY OR CREMATORY East Cemetery	22d. LOCATION (City, town, or county) (State) Army General Cemetery 3rd
23. FUNERAL DIRECTOR'S SIGNATURE John R. Lanning		ADDRESS Aberdeen Md.	
24a. REC'D BY REGISTRAR Nov 14-56		24b. REGISTRAR'S SIGNATURE Nellie R Perry	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar			
Joseph Raymond King		35		Male		White		Catholic		Single		None		Heart Disease		Home		November 1, 1956		10:30 AM		[Signature]		[Signature]			
Place of Birth		Date of Birth		Place of Death		Date of Death		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
St. Louis, Mo.		12/15/21		St. Louis, Mo.		11/1/56		Heart Disease		Home		11/1/56		10:30 AM		[Signature]		[Signature]		11/1/56		10:30 AM		[Signature]		[Signature]	
Place of Birth		Date of Birth		Place of Death		Date of Death		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
St. Louis, Mo.		12/15/21		St. Louis, Mo.		11/1/56		Heart Disease		Home		11/1/56		10:30 AM		[Signature]		[Signature]		11/1/56		10:30 AM		[Signature]		[Signature]	

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NOV 19 1956
BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11411 CERTIFICATE OF DEATH

11390

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTRY <i>Harford</i>	STATE <i>Md</i>	COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Street Rural</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Street Rural</i>	TOWN <i>Street Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Mary E Knight</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Nov 16 1956</i>	
SEX <i>Female</i>	5. COLOR OR RACE <i>White</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan 20, 1891-65</i>
10e. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) <i>Housework at home</i>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>65</i> yrs.	11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>
13. FATHER'S NAME <i>Phillip Morris</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	14. MOTHER'S MAIDEN NAME <i>Augusta Kertner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>	16. SOCIAL SECURITY NO. <i>No</i>	17. INFORMANT & ADDRESS <i>Walter Knight</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION <i>Darlington Md</i>	
151X IMMEDIATE CAUSE (A) <i>Carcinoma of Stomach</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>June 1956</i>	19b. MAJOR FINDINGS OF OPERATION <i>CARCINOMA of Stomach</i>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. et work <input type="checkbox"/> Not while et work <input type="checkbox"/>	21e. INJURY OCCURRED While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 1, 1955</i> , to <i>Nov 16, 1956</i> , that I last saw the deceased alive on <i>Nov 16, 1956</i> , and that death occurred at <i>5:10 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Nedley Phullen Jr.</i> M.D.		ADDRESS (Street, city, town, state) <i>Darlington Md</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>Nov 19, 1956</i>	NAME OF CEMETERY OR CREMATORY <i>Darlington Cem</i>	LOCATION (City, town, or county) <i>Harford Co. Md.</i>
24. REC'D BY REGISTRAR <i>Nov 17, 1956</i>	REGISTRAR'S SIGNATURE <i>C. V. Kirk</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey</i>	ADDRESS <i>Darlington Md</i>

185-

MEDICAL CERTIFICATION

VS A1S (4)
ISM 9/SS

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Place of registration	
13. Name of hospital		14. Name of physician		15. Name of nurse		16. Name of attendant	
17. Name of undertaker		18. Name of funeral home		19. Name of cemetery		20. Name of burial place	
21. Name of church		22. Name of minister		23. Name of sexton		24. Name of gravedigger	
25. Name of sexton		26. Name of gravedigger		27. Name of sexton		28. Name of gravedigger	
29. Name of sexton		30. Name of gravedigger		31. Name of sexton		32. Name of gravedigger	
33. Name of sexton		34. Name of gravedigger		35. Name of sexton		36. Name of gravedigger	
37. Name of sexton		38. Name of gravedigger		39. Name of sexton		40. Name of gravedigger	
41. Name of sexton		42. Name of gravedigger		43. Name of sexton		44. Name of gravedigger	
45. Name of sexton		46. Name of gravedigger		47. Name of sexton		48. Name of gravedigger	
49. Name of sexton		50. Name of gravedigger		51. Name of sexton		52. Name of gravedigger	
53. Name of sexton		54. Name of gravedigger		55. Name of sexton		56. Name of gravedigger	
57. Name of sexton		58. Name of gravedigger		59. Name of sexton		60. Name of gravedigger	
61. Name of sexton		62. Name of gravedigger		63. Name of sexton		64. Name of gravedigger	
65. Name of sexton		66. Name of gravedigger		67. Name of sexton		68. Name of gravedigger	
69. Name of sexton		70. Name of gravedigger		71. Name of sexton		72. Name of gravedigger	
73. Name of sexton		74. Name of gravedigger		75. Name of sexton		76. Name of gravedigger	
77. Name of sexton		78. Name of gravedigger		79. Name of sexton		80. Name of gravedigger	
81. Name of sexton		82. Name of gravedigger		83. Name of sexton		84. Name of gravedigger	
85. Name of sexton		86. Name of gravedigger		87. Name of sexton		88. Name of gravedigger	
89. Name of sexton		90. Name of gravedigger		91. Name of sexton		92. Name of gravedigger	
93. Name of sexton		94. Name of gravedigger		95. Name of sexton		96. Name of gravedigger	
97. Name of sexton		98. Name of gravedigger		99. Name of sexton		100. Name of gravedigger	

BUREAU V. S.

NOV 20 1956

RECEIVED

8-10-56

11412 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Arizona COUNTY Harford Maricopa	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryman Phenix	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, APG, Md		d. STREET ADDRESS 821 N. 5th Street General Delivery	
3. NAME OF DECEASED (Type or print) First Middle Last Lonnie Allen Lowry		4. DATE OF DEATH Month Day Year November 18 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Allen Lowry		14. MOTHER'S MAIDEN NAME Sharon Elaine Frisbie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address (as in 2 above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 18, 19 56, to Nov 18, 19 56, that I last saw the deceased alive on November 18, 19 56, and that death occurred at 18:34p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John E. Garring</i>		ADDRESS (Street, city or town, state) DATE SIGNED US Army Hospital, Aberdeen Proving Ground, Md Nov 18, 1956	
PHYSICIAN'S NAME (Type) HEINO ALARI, Capt, MC			
22a. BURIAL, CREMATION, or other disposal (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	11/23/56	Post Cemetery	Aberdeen Proving Ground
23. FUNERAL DIRECTOR'S SIGNATURE <i>John E. Garring</i>		ADDRESS Aberdeen Md	24a. REC'D BY REGISTRAR DATE Nov 23 56
		24b. REGISTRAR'S SIGNATURE <i>Willard Perry</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician and completely filled out by the funeral director, by the funeral director, or by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John A. Smith		Male		45		1910		Maryland		Baltimore		Heart Disease		1956		10:30 AM		Home		J. A. Smith		J. A. Smith	
Occupation		Married		Single		Single		Single		Single		Single		Single		Single		Single		Single		Single	
Education		High School		High School		High School		High School		High School		High School		High School		High School		High School		High School		High School	
Religion		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic		Catholic	
Race		White		White		White		White		White		White		White		White		White		White		White	
Color		White		White		White		White		White		White		White		White		White		White		White	
Height		5' 8"		5' 8"		5' 8"		5' 8"		5' 8"		5' 8"		5' 8"		5' 8"		5' 8"		5' 8"		5' 8"	
Weight		175		175		175		175		175		175		175		175		175		175		175	
Blood Pressure		120/80		120/80		120/80		120/80		120/80		120/80		120/80		120/80		120/80		120/80		120/80	
Temperature		98.6		98.6		98.6		98.6		98.6		98.6		98.6		98.6		98.6		98.6		98.6	
Pulse		72		72		72		72		72		72		72		72		72		72		72	
Respiration		16		16		16		16		16		16		16		16		16		16		16	
Mental Status		Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal		Normal	
Physical Status		Good		Good		Good		Good		Good		Good		Good		Good		Good		Good		Good	
Social Status		Good		Good		Good		Good		Good		Good		Good		Good		Good		Good		Good	
Economic Status		Good		Good		Good		Good		Good		Good		Good		Good		Good		Good		Good	
Habitual Occupation		None		None		None		None		None		None		None		None		None		None		None	
Habitual Residence		None		None		None		None		None		None		None		None		None		None		None	
Habitual Cause of Death		None		None		None		None		None		None		None		None		None		None		None	
Habitual Date of Death		None		None		None		None		None		None		None		None		None		None		None	
Habitual Time of Death		None		None		None		None		None		None		None		None		None		None		None	
Habitual Place of Death		None		None		None		None		None		None		None		None		None		None		None	
Habitual Signature of Physician		None		None		None		None		None		None		None		None		None		None		None	
Habitual Signature of Registrar		None		None		None		None		None		None		None		None		None		None		None	

NOV 26 1956

BUREAU A. K.

RECEIVED

11/23/56
John P. Brown
1st Assistant
Registrar

11413 CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Scott First Mc Diarmid Last		4. DATE OF DEATH Month Nov. Day 28 Year 19 56	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.,	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 218-10-9573		17. INFORMANT (Administrator) Address Howard K. Mc Comas, Jr., Abingdon, Maryland.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cremia 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c) Metastatic Carcinoma of Prostate			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/14 , 19 55 , to 11/27 , 19 56 , that I last saw the deceased alive on 11/27 , 19 56 , and that death occurred at 3:00 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George T. Stansbury		ADDRESS (Street, city or town, state) DATE SIGNED 569 Revolution St., Havre de Grace, Md 11/30/56	
PHYSICIAN'S NAME (Type) George T. Stansbury			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Dec. 2, 1956	22c. NAME OF CEMETERY OR CREMATORY Community Baptist	22d. LOCATION (City, town, or county) (State) Joppa, Harford, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Mc Comas & Son		ADDRESS Abingdon, Maryland.	24a. REC'D BY REGISTRAR Dec 3, 1956
		24b. REGISTRAR'S SIGNATURE Norma G. Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. The page should be removed carbon papers. Pages 1, 2, and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. B.

DEC 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11394

11389 CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hosp.</u>		d. STREET ADDRESS <u>848 Ontario ST.</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN Walter</u> First Middle Last <u>McVey</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>2</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 2, 1884</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A.</u>	
13. FATHER'S NAME <u>Joseph L. McVey</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE JOLLINGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>CARRIE BARNHART</u> Address <u>848 Ontario St. Harre de grace Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage Hemiplegia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-26</u> , 19 <u>56</u> , to <u>11-2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-2</u> , 19 <u>56</u> , and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Harre de Grace, Md</u> DATE SIGNED <u>11-3-56</u>			
ACTUAL SIGNATURE <u>C. L. Lewis</u> M.D.			
PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>		<u>Harre de Grace, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-4-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		22d. LOCATION (City, town, or county) (State) <u>HARRE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Madison Mitchell</u> ADDRESS <u>Harre de Grace Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 11-3-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>C. L. Lewis M.D.</u>	

BUREAU V. S.

NOV 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11414 CERTIFICATE OF DEATH

Reg. Dist. No.

11395

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARTFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELL AIR RURAL</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELL AIR RD 1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS LEE MANNIKHUSSEN</u>				4. DATE OF DEATH Month Day Year <u>Nov 7 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <u>Oct 16 - 1873</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>House Duties</u>		11. BIRTHPLACE (State or foreign country) <u>BELL AIR RD 1</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Mannikhussen</u>				14. MOTHER'S MAIDEN NAME <u>Louise Wyatt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		(If yes, give post office of service)		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <u>Miss Louise W Mannikhussen</u> Address <u>BELL AIR RD 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO CARDIO-RESP. FAILURE</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>APOPLEXY DUE TO EMBOLUS</u> DUE TO (c) <u>FIBRILLATION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>3 DAYS</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>7 Nov</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 Nov</u> , 19 <u>56</u> , and that death occurred at <u>12:50</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. P. Sidwell</u>				ADDRESS (Street, city or town, state) <u>401 Franklin Bell Air Md</u>			
PHYSICIAN'S NAME (Type) <u>H. P. SIDWELL MD</u>				DATE SIGNED <u>7 Nov 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov 9/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Springs Episcopal</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Hill Hartford MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. L. Belan</u>				ADDRESS <u>not</u>		24a. REC'D BY REGISTRAR <u>DATE 11-7-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Priscilla L. Howard</u>	

CERTIFICATE OF DEATH

First Name

Last Name

Age

Sex

Marital Status

Place of Birth

Place of Death

Date of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Physician's Signature

BUREAU V

NOV 9 1956

RECEIVED

11-11-56

11-11-56

11-11-56

11-11-56

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11390 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11396

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Harford</u>		c. LENGTH OF STAY IN 1b <u>Tuppa</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Manderaville</u>	
3. NAME OF DECEASED (Type or print) <u>Addie C. Osborne</u>		4. DATE OF DEATH <u>November 11</u> 19 <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 7, 1909</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Feeder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cannery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Cyrus</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-22-4279</u>	
17. INFORMANT <u>Edward Osborne</u> Address <u>Joppa Maryland.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto type - pedestrian</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-11-56</u> <u>7:00 p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 7</u>		20f. (City or town) <u>Joppa</u> (County) <u>Harford</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>11-12-56</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Nov. 15, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Community Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u> ADDRESS <u>Abingdon Maryland.</u>		24a. REC'D BY REGISTRAR <u>Nov 16, 1956</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for various conditions and a large area for handwritten notes.

RECEIVED
NOV 19 1956
BUREAU V. S.

11391

CERTIFICATE OF DEATH

11397

Reg. Dist. No.

181

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>461 W Bel Air Ave.</u>		d. STREET ADDRESS <u>461 W Bel Air Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>E.</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>1st</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16 - 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1st</u> Hours <u>1st</u> Min.	IF UNDER 24 HRS. Hours <u>1st</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Woodworker Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture etc</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Leonard Reed</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Mareva Evans</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>126-07-4136A</u>		17. INFORMANT <u>Allan D Reed</u> Address <u>461 W Bel Air Aberdeen</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Dis</u> DUE TO (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>1 mo.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>January</u> , 19 <u>51</u> , to <u>11/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/29</u> , 19 <u>56</u> , and that death occurred at <u>10:35 A.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.		ADDRESS (Street, city or town, state) <u>8 Law St. Aberdeen, Md.</u>	
DATE SIGNED <u>11/1/56</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>Nov 4 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Aberdeen Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Carrying Aberdeen Maryland</u>	
24a. REC'D BY REGISTRAR <u>Nov 3 56</u>		24b. REGISTRAR'S SIGNATURE <u>Hellie K Perry</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>April 15, 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Engineer</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		17. SIGNATURE OF DECEASED <i>John J. Smith</i>		18. SIGNATURE OF WITNESSES <i>None</i>	
19. SIGNATURE OF REGISTRAR <i>None</i>		20. SIGNATURE OF CLERK <i>None</i>		21. SIGNATURE OF JURY <i>None</i>	

BUREAU V. S.

APR 17 1956

RECEIVED

11415 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

180

1. PLACE OF DEATH a. COUNTY <u>Harpford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. LENGTH OF STAY IN 1b <u>None</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Route 40</u>				d. STREET ADDRESS <u>1564 Moreland Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>James C.</u> Middle <u>Roundtree</u> Last				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>E</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 2 - 1919</u>		9. AGE (In years last birthday) <u>37</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Grifton N.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Reginald Roundtree</u>				14. MOTHER'S MAIDEN NAME <u>IOYICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>243-16-0347</u>		17. INFORMANT Address <u>Charles Roundtree 1554 Moreland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture skull</u> 819x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture mandible + R Tibia + R Radius</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH <u>-</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto object type</u>					
20c. TIME OF INJURY Month, Day, Year <u>11-17-56</u> Hour <u>11:36</u> AM <u>PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>U.S. Route 40</u>		20f. (City or town) (County) (State) <u>Edgewood Harford MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerard C. Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gerard C. Palmer MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County 11-17-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>20 NOV. 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grifton Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Grifton N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Wright 2700 Edmondson Ave.</u>				24a. REC'D BY REGISTRAR <u>Norma Moore</u>		24b. REGISTRAR'S SIGNATURE <u>DATE Nov. 19, 1956</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. OCCUPATION: *Teacher*

5. PLACE OF BIRTH: *John Doe, Baltimore, Md.*

6. DATE OF BIRTH: *Jan 15, 1910*

7. DATE OF DEATH: *Nov 20, 1956*

8. TIME OF DEATH: *10:30 AM*

9. PLACE OF DEATH: *Home*

10. CAUSE OF DEATH: *Myocardial Infarction*

11. MANNER OF DEATH: *Natural*

12. SIGNATURE OF EXAMINER: *[Signature]*

13. SIGNATURE OF NEXT OF KIN: *[Signature]*

14. SIGNATURE OF WITNESS: *[Signature]*

15. SIGNATURE OF CORONER: *[Signature]*

16. SIGNATURE OF JURY: *[Signature]*

17. SIGNATURE OF JUDGE: *[Signature]*

18. SIGNATURE OF CLERK: *[Signature]*

19. SIGNATURE OF RECORDS: *[Signature]*

20. SIGNATURE OF ARCHIVE: *[Signature]*

21. SIGNATURE OF POSTAL: *[Signature]*

22. SIGNATURE OF TELEPHONE: *[Signature]*

23. SIGNATURE OF RAILROAD: *[Signature]*

24. SIGNATURE OF AIRCRAFT: *[Signature]*

25. SIGNATURE OF MARINE: *[Signature]*

26. SIGNATURE OF NAVY: *[Signature]*

27. SIGNATURE OF ARMY: *[Signature]*

28. SIGNATURE OF AIR FORCE: *[Signature]*

29. SIGNATURE OF SPACE: *[Signature]*

30. SIGNATURE OF OTHER: *[Signature]*

BUREAU V. 3

NOV 20 1956

RECEIVED

11416 CERTIFICATE OF DEATH

Reg. Dist. No.

18

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Forest Hills</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Forest Hills,</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <i>CHARLOTTE</i> Middle <i>CRANFORD</i> Last <i>SCARFF</i>				4. DATE OF DEATH Month <i>NOV</i> Day <i>21</i> Year <i>1956</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 6, 1891</i>	9. AGE (In years last birthday) <i>65</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>George C. Cranford</i>				14. MOTHER'S MAIDEN NAME <i>Anna Ward</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mr. William G. Scarff, Forest Hill, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>CARDIO-RESPIRATORY FAILURE</i> <i>334 x</i> DUE TO (b) <i>APOPLEXY</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>HYPERTENSION</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 DAYS</i> <i>3 DAYS</i> <i>10 YRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>— 19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1955</i> to <i>21 NOV 1956</i> , that I last saw the deceased alive on <i>20 NOV 1956</i> , and that death occurred at <i>11:40 A.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>H. P. Sidwell</i>				ADDRESS (Street, city or town, state) <i>BEL AIR, MD.</i>			
PHYSICIAN'S NAME (Type) <i>H. P. SIDWELL M.D.</i>				DATE SIGNED <i>BEL AIR, MD.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/24/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Belair Memorial Garden</i>		22d. LOCATION (City, town, or county) (State) <i>Belair, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 26 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Krisella Fowndes</i>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18

Form 214-1-1

DECEASED'S NAME [Faint text]		SEX [Faint text]		AGE [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		MARRIAGE [Faint text]	
DECEASED'S ADDRESS [Faint text]		DECEASED'S OCCUPATION [Faint text]		DECEASED'S RELIGION [Faint text]		DECEASED'S RACE [Faint text]		DECEASED'S COLOR [Faint text]		DECEASED'S SEX [Faint text]	
DECEASED'S MANNER OF DEATH [Faint text]		DECEASED'S CAUSE OF DEATH [Faint text]		DECEASED'S PLACE OF DEATH [Faint text]		DECEASED'S TIME OF DEATH [Faint text]		DECEASED'S DATE OF DEATH [Faint text]		DECEASED'S TIME OF DEATH [Faint text]	
DECEASED'S SIGNATURE [Faint text]		DECEASED'S ADDRESS [Faint text]		DECEASED'S OCCUPATION [Faint text]		DECEASED'S RELIGION [Faint text]		DECEASED'S RACE [Faint text]		DECEASED'S COLOR [Faint text]	
DECEASED'S MANNER OF DEATH [Faint text]		DECEASED'S CAUSE OF DEATH [Faint text]		DECEASED'S PLACE OF DEATH [Faint text]		DECEASED'S TIME OF DEATH [Faint text]		DECEASED'S DATE OF DEATH [Faint text]		DECEASED'S TIME OF DEATH [Faint text]	
DECEASED'S SIGNATURE [Faint text]		DECEASED'S ADDRESS [Faint text]		DECEASED'S OCCUPATION [Faint text]		DECEASED'S RELIGION [Faint text]		DECEASED'S RACE [Faint text]		DECEASED'S COLOR [Faint text]	

RECEIVED

NOV 26 1956

BUREAU V

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11417 Maryland STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 8 FilmG207 11-21-56 et
CERTIFICATE OF DEATH

11400

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN 1b lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
3. NAME OF DECEASED (Type or print) First Barbara Middle M. Last Shillman		4. DATE OF DEATH Month Nov. Day 10 Year 19 56	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885 Nov. 26, 1873
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.,	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME August Punte		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-24-6935	
17. INFORMANT George A. Shillman, Aberdeen, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with DUE TO (c) hypertension		INTERVAL BETWEEN ONSET AND DEATH within one hour years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1958 , to Nov 10 , 1956 , that I last saw the deceased alive on Nov 9 , 1956 , and that death occurred at 2:30 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Fred O Hodous M.D.		ADDRESS (Street, city or town, state) Edgewood Md DATE SIGNED 11-11-56	
PHYSICIAN'S NAME (Type) Fred O. Hodous		Edgewood Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 13, 1956	22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran	22d. LOCATION (City, town, or county) (State) Joppa, Harford, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son		ADDRESS Abingdon Md	
24a. REC'D BY REGISTRAR Nov 13, 1956		24b. REGISTRAR'S SIGNATURE Norma S. Moore	

NOV 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11418 CERTIFICATE OF DEATH

11401

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, Rural				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				d. STREET ADDRESS Edgewood			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last George H. Shillman				4. DATE OF DEATH Month Day Year Nov. 16 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1875	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel F. Shillman				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 716-01-9049		17. INFORMANT Address George A. Shillman, Aberdeen, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis & V disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-15 , 1955 , to 11-16 , 1956 , that I last saw the deceased alive on 11-15 , 1956 , and that death occurred at 3 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bel Air, Md. DATE SIGNED 11-17-56 ACTUAL SIGNATURE Gerald C Palmer M.D. PHYSICIAN'S NAME (Type) Gerald C. Palmer M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1956		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran		22d. LOCATION (City, town, or county) (State) Joppa, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son Howard K. McComas				ADDRESS Abingdon Md.		24a. REC'D BY REGISTRAR Nov 17, 1956	
				24b. REGISTRAR'S SIGNATURE Norma B. Moore			

BUREAU A. 3.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11392 CERTIFICATE OF DEATH

11402

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford & Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial</u>				d. STREET ADDRESS <u>Route #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Gerald</u> Middle <u>Stanley</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/15/19</u>	9. AGE (In years last birthday) <u>6</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Wade B. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Helen (Hoff) Mustard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Wade B. Smith - Aberdeen #1-Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u>							<u>2 days</u>
DUE TO <u>577X</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia & gangrenous ileum</u>							<u>2 days</u>
(c) <u>Strangulation & fibrous adhesion</u>							<u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11/16/56</u> , 19 <u>56</u> , to <u>11/15/56</u> , that I last saw the deceased alive on <u>11/15/56</u> , 19 <u>56</u> , and that death occurred at <u>9:57 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin Wachsmen</u>				ADDRESS (Street, city or town, state) <u>Hartford & Grace Md</u> DATE SIGNED <u>11/17/56</u>			
PHYSICIAN'S NAME (Type) <u>Irvin Wachsmen</u>				<u>Hartford & Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rd. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Garroway</u> ADDRESS <u>Aberdeen, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN		19. SIGNATURE OF JUDGE		20. SIGNATURE OF JURY	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF CLERGYMAN		24. SIGNATURE OF JUDGE		25. SIGNATURE OF JURY	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF CLERGYMAN		29. SIGNATURE OF JUDGE		30. SIGNATURE OF JURY	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF CLERGYMAN		34. SIGNATURE OF JUDGE		35. SIGNATURE OF JURY	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF CLERGYMAN		39. SIGNATURE OF JUDGE		40. SIGNATURE OF JURY	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF JUDGE		45. SIGNATURE OF JURY	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF CLERGYMAN		49. SIGNATURE OF JUDGE		50. SIGNATURE OF JURY	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF CLERGYMAN		54. SIGNATURE OF JUDGE		55. SIGNATURE OF JURY	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF CLERGYMAN		59. SIGNATURE OF JUDGE		60. SIGNATURE OF JURY	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF CLERGYMAN		64. SIGNATURE OF JUDGE		65. SIGNATURE OF JURY	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF CLERGYMAN		69. SIGNATURE OF JUDGE		70. SIGNATURE OF JURY	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF CLERGYMAN		74. SIGNATURE OF JUDGE		75. SIGNATURE OF JURY	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF CLERGYMAN		79. SIGNATURE OF JUDGE		80. SIGNATURE OF JURY	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF JUDGE		85. SIGNATURE OF JURY	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF CLERGYMAN		89. SIGNATURE OF JUDGE		90. SIGNATURE OF JURY	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF CLERGYMAN		94. SIGNATURE OF JUDGE		95. SIGNATURE OF JURY	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF CLERGYMAN		99. SIGNATURE OF JUDGE		100. SIGNATURE OF JURY	

BUREAU V. 2

NOV 21 1956

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11403

11419 CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - JOPPA</u>		LENGTH OF STAY (In this place) <u>4 1/2 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL - JOPPA</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>				STREET ADDRESS (If rural give location) <u>TRIMBLE ROAD</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>LYDIA</u> <u>JOSEPHINE</u> <u>SPARKS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>NOV. 2</u> 19 <u>56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>SEPT. 13, 1880</u>		9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN MAYS</u>				14. MOTHER'S MAIDEN NAME <u>CYNTHIA CREED</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs. Roy Moxley</u> <u>Box 498, RD #2</u> <u>JOPPA, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>						<u>6 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>						<u>several years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>GENERALIZED ARTERIOSCLEROSIS</u>						<u>several yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <u>M.</u> <u>at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> 19 <u>55</u> , to <u>NOV. 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 29</u> , 19 <u>56</u> , and that death occurred at <u>4:30</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Paul S. Straube Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. 115 FULLFORD AVE. BEL AIR, MD.</u> DATE SIGNED <u>11/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Nov. 3, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Moody Funeral Home</u>		LOCATION (City, town, or county) (State) <u>Mount Airy, Surry, N.C.</u>	
24. REC'D BY REGISTRAR <u>Nov. 4, 1956</u>		REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. McComas & Son</u>		ADDRESS <u>Abingdon Md</u>	

CERTIFICATE OF DEATH

RECEIVED
OCT 7 1956
BUREAU V. 3

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF BIRTH [Faint text]		6. PLACE OF BIRTH [Faint text]	
7. DATE OF DEATH [Faint text]		8. PLACE OF DEATH [Faint text]	
9. CAUSE OF DEATH [Faint text]		10. MANNER OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11404

11404 CERTIFICATE OF DEATH

Reg. Dist. No. 187

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Fallston</i>		LENGTH OF STAY (in this place) <i>40 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Fallston</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS —				STREET ADDRESS (If rural give location) <i>Rural</i>			
3. NAME OF DECEASED (Type or Print) <i>Asel Tollinger Starr</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Nov. 12 1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Jan. 22-1882</i>	9. AGE last birthday <i>74</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Harford Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>John Starr</i>				14. MOTHER'S MAIDEN NAME <i>Alice Tollinger</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Mrs. Elizabeth Starr</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <i>Pulmonary edema</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <i>arteriosclerotic C.V. disease</i>						<i>6 mo</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <i>MD</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>6/15</i> , 19 <i>56</i> , to <i>11-12</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>11-12</i> , 19 <i>56</i> , and that death occurred at <i>6 P.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>David C. Palmer</i>				M.D. <i>Bea A. in, Md.</i>		DATE SIGNED <i>11-13-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Nov. 15 56</i>		NAME OF CEMETERY OR CREMATORY <i>Mountain Christian</i>		LOCATION (City, town, or county) (State) <i>Joppa - Md</i>	
24. REC'D BY REGISTRAR <i>NOV 16 1956</i>		REGISTRAR'S SIGNATURE <i>W. H. Archer</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Archer - Benson, Md.</i>		ADDRESS	

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. RACE

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

BUREAU V. B.

NOV 16 1956

RECEIVED

NOTICE

NOTICE TO THE PUBLIC: This is to certify that the foregoing is a true and correct copy of the original record as it appears in the files of the Department of Health, State of Maryland, and is subject to the provisions of the laws of this State relating to the recording and filing of death records.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11406/1

11421

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>US Route 40</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Charles H. Thompson</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16 - 1916</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Martin Air Craft.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Lee Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Ollie Jane Blevers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>391-03-5755</u>	
17. INFORMANT <u>Wm Chas S. Parlier</u>		Address <u>Belt Ave #1 - Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture spine</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>819x</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crushing injury chest</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto-object type</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-30-56</u> Hour a. m. <u>2</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u>		20f. (City or town) <u>Aberdeen</u> (County) <u>Harford</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Lerald C Palmer</u>		DATE SIGNED <u>11-30-56</u>	
EXAMINER'S NAME (Type) <u>Gerold C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12/1/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bristol Tenn.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Sarring</u>		ADDRESS <u>Aberdeen Maryland</u>	
24a. REC'D BY REGISTRAR <u>11-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Nellie R Perry</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

Reg. Dist. No. **11407**

VS A15 (4)
ISM 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11394 CERTIFICATE OF DEATH

Reg. Dist. No. 11498

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rock Springs Road</u>				d. STREET ADDRESS <u>Rock Springs Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Martin</u> Middle <u>Townsley</u> Last				4. DATE OF DEATH Month <u>November</u> Day <u>17</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 31, 1891</u>	9. AGE (In years lost birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Townsley</u>				14. MOTHER'S MAIDEN NAME <u>Nora Coe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-14-1402</u>			
				17. INFORMANT <u>Mrs. Lillie W. Townsley, Forest Hill, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Chr. Cardio-vascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>45 Min.</u> <u>10 yrs ?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary artery disease (Coronary Insufficiency; Cor. Thrombosis)</u> <u>one attack-1950</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>Forest Hill, Md.</u>		(County) (State)	
21. I certify that I attended the deceased from <u>May 10</u> , 1950, to <u>Nov. 17</u> , 1956, that I last saw the deceased alive on <u>Nov. 17</u> , 1956, and that death occurred at <u>7:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>				DATE SIGNED <u>November 19, 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>				ADDRESS <u>Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>11-19-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Russella L. Woodward</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11409

11395 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
32 TOWN <i>Belt-Air</i>		40 yrs.		37 TOWN <i>Belt-Air</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Toll Gate Rd.</i>				STREET ADDRESS (If rural give location) <i>Toll Gate Rd.</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
MAMIE A. TURNER				11 26 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Negro	married	March 12, 1891	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Housewife		Housewife		Kalamia Md.		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Williams				Rachel Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		213-18-6830		Mr. William H. Turner - Belt-Air, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
155x IMMEDIATE CAUSE (A)						Generalized Metastatic Carcinoma	
ANTECEDENT CAUSE(S) DUE TO						Carcinoma of Gall-bladder	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>March 1953</i> to <i>Nov 26, 1956</i> , that I last saw the deceased alive on <i>Nov 24, 1956</i> , and that death occurred at <i>3:15 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Willard P. Hudson</i> M.D.				ADDRESS (Street, city, town, state) <i>Forest Hill, Md.</i>		DATE SIGNED <i>11/26/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
Burial	11-29-56	Clark's Chapel Cemetery		Kalamia, Md.			
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>11-27-56</i>	<i>Priscilla Louwood</i>			<i>Otelia J. Bullock</i>		<i>Harve de Grace, Md.</i>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

TO BE FILLED BY THE REGISTRAR OF DEATHS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO TOWN

DATE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO PARISH

DATE OF ENTRY INTO CHURCH

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO COFFIN

DATE OF ENTRY INTO GRAVE

DATE OF ENTRY INTO CEMETERY

DATE OF ENTRY INTO BURIAL

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO TOWN

DATE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO PARISH

DATE OF ENTRY INTO CHURCH

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO COFFIN

DATE OF ENTRY INTO GRAVE

DATE OF ENTRY INTO CEMETERY

DATE OF ENTRY INTO BURIAL

BUREAU V. S.

NOV 29 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for use by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hanford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Puerto Rico</u> COUNTY <u>Morrito Nation</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DOA APE Station Nsp</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gagey</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>US Army Hqpt. APO. Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jose E Matos-Vazquez</u>		4. DATE OF DEATH <u>November 30</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10-1926</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>us army</u>	9. AGE (In years last birthday) <u>27</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Puerto Rico</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Candres Vazquez</u>		14. MOTHER'S MAIDEN NAME <u>Juanita Vazquez</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>but 4/4/1951</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>official us army records</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull Injury</u> DUE TO <u>819x</u> Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c) <u>—</u> DUE TO <u>—</u> causing the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident out auto-ob; not type</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-30-56</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Army Hqpt</u>	20f. (City or town) <u>Barrio Rincon-Cayey</u> (County) <u>Puerto Rico</u> (State) <u>P.R.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		DATE SIGNED <u>11-30-56</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>12/7/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Municipal</u>	22d. LOCATION (City, town, or county) <u>Barrio Rincon-Cayey</u> (State) <u>Puerto Rico</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Garring</u> ADDRESS <u>abertson rd.</u>		24a. REC'D BY REGISTRAR <u>Dec 6-56</u>	24b. REGISTRAR'S SIGNATURE <u>Nellie R. Perry</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 10 1953

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11410

Florence I. Walter

11423

CERTIFICATE OF DEATH

Reg. Dist. No. 187

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Md.		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Street t		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Street t			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) FLORENCE (Middle) I. (Last) WALTER				4. DATE OF DEATH (Month) Nov. (Day) 6, (Year) 1956			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Jan. 21, 1903	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John D. Iley				14. MOTHER'S MAIDEN NAME Elizabeth Stansbury			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs. Florence I. Walter - Street, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
154X IMMEDIATE CAUSE (A) CARCINOMA WITH METASTASIS						6 mo. +	
ANTECEDENT CAUSE(S) DUE TO (B) CARCINOMA OF RECTUM						"	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION JUNE 1956		19b. MAJOR FINDINGS OF OPERATION CARCINOMA OF RECTUM				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 21, 1956, to Nov. 6, 1956, that I last saw the deceased alive on Nov. 5, 1956, and that death occurred at 10 A.M. from the causes and on the date stated above.							
SIGNATURE Charles A. Duff M.D.				ADDRESS (Street, city, town, state) STREET, MARYLAND. 11-6-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/8/56		NAME OF CEMETERY OR CREMATORY Highland Presby. Cem.		LOCATION (City, town, or county) Streett, Harford, Co. Md.	
24. RECEIVED BY REGISTRAR DATE Nov. 7, 1956		REGISTRAR'S SIGNATURE Priscilla Forewood		25. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichener & Sons		ADDRESS Balt. Md.	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		OCCUPATION		EDUCATION	
RELIGION		MARITAL STATUS		DATE OF BIRTH	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	

CARCINOMA OF RECTUM
CARCINOMA WITH METASTASIS

BUREAU V. S.

NOV 8 1956

RECEIVED

STREET

11396 CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>			
c. LENGTH OF STAY IN 1b <u>5 hrs.</u>				d. STREET ADDRESS <u>847 Erie Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joshua</u> Middle <u>Edward</u> Last <u>Williams</u>				4. DATE OF DEATH Month <u>11</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 3, 1875</u>	
9. AGE (In years last birthday) <u>81 yrs.</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> Hours <u>1956</u>		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truckman (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Penna Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Perryman, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Williams</u>				14. MOTHER'S MAIDEN NAME <u>Annie Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>717-07-5674</u>		17. INFORMANT Address <u>847 Erie St.</u> <u>Mrs. Edna Johnson - Harre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/16</u> , 19 <u>50</u> , to <u>11/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>56</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>509 Revolution St., Harre de Grace, Md.</u> DATE SIGNED <u>11/14/56</u> ACTUAL SIGNATURE <u>George T. Stansbury, M.D.</u> PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> <u>HARRE DE GRACE, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>A. Berdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock, Harre de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 11-16-56</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Dennis, Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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EDITION

11424 CERTIFICATE OF DEATH

11412

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Hartford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY Hartford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EMMORTON RURAL		c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EMMORTON RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FANNY Middle KENNARD Last WILSON				4. DATE OF DEATH Month Nov Day 2 Year 1956			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 28 - 1878		9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW YORK, N.Y.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Joseph S. Kennard				14. MOTHER'S MAIDEN NAME Nancy R. Jeffers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT Robert H. Wilson (Bel Air MD) Box 226			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESP FAILURE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A. S. C. V. D. DUE TO (c) ADVANCED YEARS						INTERVAL BETWEEN ONSET AND DEATH 1 HR 1 YEAR. 1 YEAR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Bel Air MD		(County) (State)	
21. I certify that I attended the deceased from 1955 , to 2 Nov 1956 , that I last saw the deceased alive on 3 Aug 1956 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. P. Belair				ADDRESS (Street, city or town, state) Bel Air MD		DATE SIGNED 2 Nov 56	
PHYSICIAN'S NAME (Type) Joseph J. L. Belair MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov 4/56		22c. NAME OF CEMETERY OR CREMATORY St Mary Episcopal		22d. LOCATION (City, town, or county) (State) EMMORTON Hartford MD	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. L. Belair MD				24a. REC'D BY REGISTRAR 11-4-56		24b. REGISTRAR'S SIGNATURE Phyllis Fourwood	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED HARTFORD		SEX M	
BIRTH JAN 25 1901		PLACE OF BIRTH EMERYTON, MD	
DECEASED F		SEX F	
BIRTH WHITE		PLACE OF BIRTH NEW YORK, N.Y.	
DECEASED JOSEPH J. HARTFORD		SEX M	
BIRTH JAN 25 1901		PLACE OF BIRTH EMERYTON, MD	
DECEASED NANCY J. HARTFORD		SEX F	
BIRTH JAN 25 1901		PLACE OF BIRTH EMERYTON, MD	

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JOSEPH J. HARTFORD
 JAN 25 1901
 EMERYTON, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11397 CERTIFICATE OF DEATH

Reg. Dist. No. 183

11413

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>322 N Union Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Dan</u> Middle <u>Wright</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/20/1874</u>	9. AGE (In years last birthday) <u>82</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Deane H. Bristow</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Clarence F. Wright</u> Address <u>322 N Union Ave Harford, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>A.S.C.V.D. and H.C.V.D.</u> DUE TO (c) <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 - Diabetes mellitus 2 - Pyelonephritis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 27th, 1956</u> , to <u>Nov. 27th, 1956</u> , that I last saw the deceased alive on <u>Nov. 27th, 1956</u> , and that death occurred at <u>9:07</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.				ADDRESS <u>211 N Union Ave</u>		DATE SIGNED <u>11/27/56</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				ADDRESS <u>Harford, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clarence F. Wright</u> ADDRESS <u>Harford, Md.</u>				24a. REC'D BY REGISTRAR <u>U. S. L. Loo</u>		24b. REGISTRAR'S SIGNATURE <u>U. S. L. Loo</u>	

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11414

11425 CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY HARFORD	MARYLAND	STATE Md.	COUNTY Washington
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EDGEWOOD	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sharpsburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS ARMY CHEMICAL CENTER		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) JERRY (First) C. W. (Middle) YARRAD (Last)		4. DATE OF DEATH Nov 14 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Nov. 23, 1901
9. AGE last birthday 54 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Yarrad		14. MOTHER'S MAIDEN NAME -- Lentz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) World War No. 1		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Balto. 14, Md. Mrs. Muriel Yarrad - 8515 Oakleigh Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH 1 HR 15 MIN	
ANTECEDENT CAUSE(S) DUE TO (B) CORONARY ARTERIOSCLEROSIS		2-3 YRS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov 14, 1956 , to Nov 14, 1956 , that I last saw the deceased alive on Nov 14, 1956 , and that death occurred at 2:00 PM , from the causes and on the date stated above.			
SIGNATURE William Lewis Stewart , M.D.		ADDRESS (Street, city, town, state) EDGEWOOD, MD. DATE SIGNED Nov. 14, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 11/19/56	NAME OF CEMETERY OR CREMATORY Arlington National Cem LOCATION (City, town, or county) Arlington, Va.	
24. REC'D BY REGISTRAR Nov 19 1956	REGISTRAR'S SIGNATURE Norma G. Moore	25. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS, Inc. ADDRESS Balto. 17, Md	

CERTIFICATE OF DEATH

FILE NO.

A. QUALITY OF DEATH OF DECEASED

DATE OF DEATH

TIME

PLACE

NAME OF DECEASED

AGE

CAUSE OF DEATH

DATE OF BIRTH

SEX

DATE OF DEATH

TIME

PLACE

NAME OF DECEASED

DATE OF BIRTH

SEX

DATE OF DEATH

TIME

PLACE

NAME OF DECEASED

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DATE OF BIRTH

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DATE OF DEATH

TIME

PLACE

NAME OF DECEASED

BUREAU V. 2

NOV 19 1956

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